# Medi-Cal Provider Enrollment

**Enrollment as a Facility-Based Provider Practicing *Exclusively* in a Licensed Health Facility (as defined in the California Health and Safety Code, Section 1250)**
**("Facility-Based Provider")**

The *Welfare and Institutions Code* (W & I Code), Section 14043.15, requires that certain people who are licensed or certificated to provide health care (persons), or professional corporations shall enroll in Medi-Cal as either individual providers or as rendering providers in a provider group. Section 14043.15 also provides that if such a person's or professional corporation's practice includes the rendering of services solely at one or at more than one licensed health facility, the person or professional corporation shall not be required to enroll at each licensed health facility.

This bulletin is about the enrollment of persons or professional corporations delivering services *exclusively* in licensed health facilities (as defined in the *California Health and Safety Code*, Section 1250 et seq.).

In order to be enrolled in Medi-Cal and unless exempted in this bulletin, persons or professional corporations delivering services *exclusively* in licensed health facilities must enroll as either individual providers or as rendering providers in a provider group and satisfy the same requirements as other applicants or providers and meet requirements appropriate to the services they deliver. However, since persons or professional corporations that render services exclusively at licensed health facilities will not have a separate, independent practice location, the Department of Health Services (DHS) shall allow such a person or professional corporation to enroll in Medi-Cal as an individual provider or a rendering provider in a provider group, provided that each such person or professional corporation and each licensed health facility at which the person or professional corporation provides services meets the following requirements.

Withdrawn

These requirements are adopted upon the authority granted the director of DHS in W & I Code, Section 14043.75(b) and have the full force and effect of law. These requirements are effective for all application packages received on or after August 16, 2004.

- Each health facility in which the person or professional corporation seeking Medi-Cal enrollment as a "facility-based provider" renders services is currently licensed and enrolled in the Medi-Cal program; and

- There are no currently pending or outstanding Medi-Cal, Medicaid, Medicare or licensing sanctions against the person or the professional corporation seeking Medi-Cal enrollment as a "facility-based provider" or against the health facility at the time of application; and

- Each health facility in which the person or professional corporation seeking Medi-Cal enrollment as a "facility-based provider" will render services

    - routinely enters into individual contracts with all of those who provide services at the health facility, grants such providers access privileges to the licensed health facility, and retains the right to exclude such providers from the health facility for improper activities, and has entered into such an agreement with the person or the professional corporation seeking Medi-Cal enrollment as a "facility-based provider;" or

    - while not routine, has executed such a contract with the person or professional corporation seeking Medi-Cal enrollment as a "facility-based provider." [**NOTE:** Health facilities that employ staff sufficient to provide all services directly, or that have an employer-employee relationship with a person or professional corporation seeking Medi-Cal enrollment as a "facility-based provider" may not be utilized for purposes of enrollment as a "facility-based provider."]

DHS shall also consider that a person or professional corporation seeking Medi-Cal enrollment as a "facility-based provider" meets the "established place of business" requirements in W & I Code Section 14043.7 if each licensed health facility at which the person or professional corporation will provide services meets the established place of business requirements.

Based upon the authority granted in W & I Code, Section 14043.75(b), the director of DHS is also establishing the following procedures that have the full force and effect of law. These procedures are effective for all application packages received on or after August 16, 2004.

**"Facility-Based Provider" Practicing *Exclusively* in a Licensed Health Facility/Facilities (as defined in the *California Health and Safety* Code, Section 1250).**
An applicant or provider requesting consideration for enrollment as a "facility-based provider," practicing exclusively in a licensed health facility/facilities and using the licensed health facility/facilities as its established place of business must do all of the following:

1. Submit a complete application package pursuant to *California Code of Regulations* (CCR), Title 22, Section 51000 (et seq.) and print on the first page of the provider-type specific application "facility-based provider."
2. Submit with the application package a cover letter from each Medi-Cal enrolled and licensed health facility at which the "facility-based provider" will provide services. Each letter must be on the letterhead of the licensed health facility and include the following:

    a. Date of the letter

    b. Name and location of the currently licensed and Medi-Cal enrolled health facility

    c. Description of the applicant's or provider's professional relationship with the licensed health facility

    d. The statement: "I, (person authorized to legally bind the licensed health care facility) understand that (applicant or provider) has submitted an application package for enrollment in the Medi-Cal program as a "facility-based provider" indicating that (applicant or provider) provides services under contract at (licensed health care facility). I further understand that approval of the application package is based in part on the contractual agreement between (applicant or provider) and (licensed health facility), and based in part on that there are no current sanctions against (licensed health care facility). Therefore, I attest that a contractual relationship does exist between (applicant or provider) and (licensed health care facility), and I attest that there are no currently pending or outstanding Medi-Cal, Medicaid or Medicare or licensing sanctions against the (licensed health care facility)."

3. Submit with the application package a cover letter in which the applicant or provider states, under penalty of perjury under the laws of the state of California the following:

    a. The applicant or provider is currently licensed to render health care services of the type and complexity coming within the level of care provided by the health care facility/facilities at which the applicant or provider will practice.

    b. The applicant or provider renders services exclusively at a licensed health facility/facilities and has no other leased or owned space or premises, where the applicant or provider provides services.

    c. The statement: "I, (applicant or provider) understand that enrollment in the Medi-Cal program as a "facility-based provider" is based in part on the contractual agreement between (applicant or provider) and (licensed health care facility) and that any change in this contractual relationship including, but not limited to, termination of the contract and/or relationship must be reported by me to the Department of Health Services within 35 days of the change. This change is in addition to any changes required to be reported in accordance with *Welfare and Institutions Code* (W & I Code), Section 14043.26(a)(1)."

4. Submit with the application package and two (2) cover letters the following statement for each Medi-Cal enrolled and licensed health facility at which the "facility-based provider" will provide services and under penalty of perjury under the laws of the State of California: "The undersigned (licensed health care facility) and the (applicant or provider) agree to and affirm that the Department of Health Services may rely on the veracity of the following statements made in enrolling the (applicant or provider) in the Medi-Cal program and issuing a Medi-Cal provider number to the (applicant or provider) as a "Facility-Based Provider." It is agreed and understood by (applicant or provider) and (licensed health care facility) that duplicate billing for services rendered to Medi-Cal beneficiaries is illegal. By signature, below, the (licensed health care facility) and (applicant or provider) ensure that claims submitted for Medi-Cal reimbursement shall not be for duplicate services and acknowledge that the (licensed health care facility) and (applicant or provider) shall be jointly and severely responsible for any repayment or penalty if a claim(s) for duplicate services is made. All claims for reimbursement for services provided by a "facility-based provider" to Medi-Cal beneficiaries shall be billed using the "facility-based provider's" provider number and shall not include services that are reimbursed to the (licensed health care facility)." The statement must also include:

    a. The name, address, city, state and zip code of the licensed health facility; the printed name and signature of the person who is authorized to legally bind the licensed health facility; the date the statement is signed; the printed name and signature of the applicant or provider, that shall be a natural person or professional corporation; and the date the statement is signed.

5. Declare under penalty of perjury under the laws of the State of California that each and every copy of the documents included in the application package requesting consideration for enrollment in Med-Cal as a "facility-based provider" or attached to the application package or a cover letter(s), is a true and correct copy of what it purports to be.

Withdrawn

**The following format may be used for the required two cover letters.**

**1. Health Care Facility Cover Letter**

I,_____, understand that
(Name of person authorized to legally bind the licensed health care facility)

_____ has submitted an application package for enrollment in the Medi-Cal program as
(Name of applicant or provider)

a "facility-based provider" indicating that _____ provides services under contract at
(Name of applicant or provider)

_____. I further understand that approval of the application package is based in part
(Name of licensed health care facility)

on the contractual agreement between and based in part on _____ and
(Name of applicant or provider)

_____, that there are no current sanctions against
(Name of licensed health care facility)

_____. Therefore, I attest that a contractual relationship does exist between
(Name of licensed health care facility)

_____ and _____ and I attest that there are no currently pending
(Name of applicant or provider) (Name of licensed health care facility)

or outstanding Medi-Cal, Medicaid or Medicare or licensing sanctions against the

_____.
(Name of licensed health care facility)

Signed this _____ day of _____, _____.
(Day of month) (Month) (Year)

In _____, California.
(Name of county where signed)

By: _____
(Printed name and title of person authorized to legally bind the licensed health care facility)

_____
(Signature of person authorized to legally bind the licensed health care facility)

Withdrawn

**2. Provider Cover Letter**

I, _____, declare under penalty of perjury under the laws of the state of California
(Name of applicant or provider)

that I am currently licensed to render health care services of the type and complexity coming within the level of care provided by _____ at which I will practice and, that I render services
(Name of licensed health care facility)

exclusively at licensed health facilities and have no other leased or owned space or premises where I provide services. Furthermore, I, _____, understand that enrollment in the
(Name of applicant or provider)

Medi-Cal program as a "facility-based provider" is based in part on the contractual agreement between _____ and _____ and that any change in this
(Name of applicant or provider) (Name of licensed health care facility)

contractual relationship including, but not limited to, termination of the contract and/or relationship must be reported by me to the Department of Health Services within 35 days of the change. This change is in addition to any changes required to be reported in accordance with *Welfare and Institutions Code*, Section 14043.26(a)(1).

Withdrawn

Signed this _____ day of _____, _____.
(Day of month) (Month) (Year)

In _____, California.
(Name of county where signed)

By: _____
(Printed name of applicant)

_____
(Signature of applicant or provider)

**3. Statement**

The undersigned _____ and the _____
(Name of licensed health care facility) (Name of applicant or provider)

agree to and affirm that the Department of Health Services may rely on the veracity of the following statements made in enrolling the _____in the Medi-Cal
(Name of applicant or provider)

program and issuing a Medi-Cal provider number to the _____as a
(Name of applicant or provider)

"facility-based provider." It is agreed and understood by _____and
(Name of applicant or provider)

_____ that _____ that
(Name of licensed health care facility) (Name of licensed health care facility)

duplicate billing for services rendered to Medi-Cal beneficiaries is illegal.

By signature, below, the _____ and
(Name of licensed health care facility)

_____ ensure that claims submitted for Medi-Cal reimbursement shall
(Name of applicant or provider)

not be for duplicate services and acknowledge that the _____ and
(Name of licensed health care facility)

_____ shall be jointly and severely responsible for any repayment or
(Name of applicant or provider)

penalty if a claim(s) for duplicate services is made. All claims for reimbursement for services provided by a "facility-based provider" to Medi-Cal beneficiaries shall be billed using the "facility-based provider's" provider number and shall not include services that are reimbursed to the _____.
(Name of licensed health care facility)

Withdrawn

We, the undersigned, declare under penalty of perjury under the laws of the State of California that the foregoing information is true and correct to the best of our knowledge.

_____
Licensed health care facility

_____ _____ _____
Address (number, street) City, State Zip Code

_____ _____ _____
Print name of person authorized to legally bind the licensed health care facility
Signature of person authorized to legally bind the licensed health care facility
Date

_____
Print applicant or provider name

_____ _____
Applicant or provider signature Date